STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46445 Based on observation, interview, and record review, the facility failed to ensure the residents received services with reasonable accommodation of the resident needs for two of three sampled residents (Residents 2 and Resident 3). Resident 2 and Resident 3, who were at risk for falls, did not have the call light (an alerting device for residents to call for assistance) within the resident ' s reach. This deficient practice had the potential for not meeting Residents 2 and 3's needs for assistance. Findings: During a record review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 7/10/2024 with diagnoses including metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), essential hypertension (an abnormally high blood pressure that was not a result of a medical condition), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]). During a record review of Resident 3 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/1/2024, the MDS indicated the resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills was severely impaired. During a record review of Resident 3 ' s Fall Risk Assessment, dated 10/27/2024, the Fall Risk Assessment indicated the resident had a total score of 12. A total score above 10 represented high risk for falls. During a record review of Resident 3 ' s Care Plan on falls, last revised on 10/27/2024, indicated the resident was high risk for falls. The Care Plan intervention indicated to be sure the resident ' s call light was within reach and encourage the resident to use it for assistance as needed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 11/14/2024 at 10:34 a.m. with the Assistant Director of Nursing (ADON), the ADON observed Resident 3 ' s call light hanging on the television (TV) rack located at the right head part of the resident ' s bed. The ADON stated Resident 3 ' s call light was not within the resident ' s reach. The ADON stated the residents used the call light to call nursing staff for assistance. The ADON stated Resident 3 ' s needs had the potential to not be met. The ADON stated Resident 3 had the potential to stand up unassisted, fall, and sustain an injury if the resident was unable to reach and use the call light to request nursing staff for assistance. The ADON stated the facility failed to ensure Resident 3 ' s call light was within the resident ' s reach. During an interview on 11/14/2024 at 12:14 p.m. with the Director of Nursing (DON), the DON stated a call light was a resident ' s way of communication to the staff. The DON stated Resident 3 ' s call light should be within the resident ' s reach. The DON stated Resident 3 ' s call light not within the resident ' s reach had the potential to cause delay in the Resident 3 ' s care. The DON stated the facility failed to ensure the call light was within Resident 3 ' s reach. During a record review of the facility ' s policy and procedure (PnP) titled, Residents Call System, last reviewed on 1/2024, indicated residents were provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. During a record review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 7/10/2024 with diagnoses including acute cerebrovascular insufficiency (a sudden and temporary lack of blood flow to the brain), essential hypertension (an abnormally high blood pressure that was not a result of a medical condition), and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a record review of Resident 2 ' s Care Plan on falls, last revised on 7/11/2024, indicated the resident was high risk for falls. The Care Plan intervention indicated to be sure the resident ' s call light was within reach and encourage the resident to use it for assistance as needed. During a record review of Resident 2 ' s MDS, dated [DATE], the MDS indicated the resident ' s cognitive skills was severely impaired. During an observation and concurrent interview on 11/14/2024 at 10:34 a.m. with the Assistant Director of Nursing (ADON), the ADON observed Resident 2 ' s call light hanging on the resident ' s right bedside rails with the call light button in between the mattress and the bedside rails. The ADON stated Resident 2 ' s call light was not visible to the resident. The ADON stated Resident 2 ' s needs had the potential to not be met if the call light was not visible and within the resident ' s reach. The ADIN stated the facility failed to ensure the Resident 2 ' s call light was within reach and was visible to the resident. During an interview on 11/14/2024 at 12:14 p.m. with the Director of Nursing (DON), the DON stated a call light was a resident ' s way of communication to the staff. The DON stated Resident 2 ' s call light should be visibly within the resident ' s reach. The DON stated Resident 2 ' s call light not within the resident ' s reach had the potential to cause delay in the Resident 2 ' s care. The DON stated the facility failed to ensure the call light was within Resident 2 ' s reach. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Valley Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13000 Victory Blvd North Hollywood, CA 91606	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility ' s policy and procedure (PnP) titled, Residents Call System, last reviewed on 1/2024, indicated residents were provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46445 Based on observation, interview, and record review, the facility failed to ensure residents receive the necessary care based on the assessed individual needs to prevent accidents and minimize injuries for one of the three sampled residents (Resident 1) by failing to: 1. Provide Resident 1 with fall mats (a soft, cushioned pad placed on the floor, designed to help absorb the impact of a fall and minimize injuries) on both sides of the resident ' s bed. 2. Ensure Resident 1 ' s risk for falls was communicated to the facility staff. The list of fall risk residents on the huddle report (a short meeting held to allow everyone on the team to know specific important information about patients) documents was inconsistent. This deficient practice had the potential to cause falls with injury or harm to Resident 1 and other residents. Findings: During a record review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 9/14/2024 with diagnoses including chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), age-related osteoporosis (a disease that causes bones to become weak and more likely to break), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a record review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/16/2024, the MDS indicated the resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills was moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. During a record review of Resident 1 ' s Fall Risk Assessment, dated 10/19/2024, the Fall Risk Assessment indicated the resident had a total score of 16. A total score above 10 represented high risk for falls. During an observation and concurrent interview on 11/14/2024 at 11:02 a.m., Resident 1 was observed sitting on a wheelchair inside Resident 1 ' s room. Resident 1 ' s room surrounding was observed with Certified Nursing Assistant 2 (CNA 2). CNA 2 stated Resident 1 used either side of the resident ' s bed to get off the bed. CNA 2 stated Resident 1 ' s overbed table was observed on top of the resident ' s fall mat located at the left side of the Resident 1 ' s bed. CNA 2 stated Resident 1 should have a fall mat on both sides of the bed. CNA 2 stated Resident 1 could get off the right side of the bed, the side without a fall mat, and had the potential to fall and sustain an injury. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Valley Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 13000 Victory Blvd North Hollywood, CA 91606	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 11/14/2024 at 11:08 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 ' s overbed table was observed on top of the resident ' s fall mat located at the left side of Resident 1 ' s bed. LVN 1 stated Resident 1 was able to get off the bed from either the left or the right side. LVN 1 stated Resident 1 ' s overbed table had the potential to cause injury or harm if the resident got off the left side of the bed. LVN 1 stated Resident 1 had the potential to fall and sustain an injury such as fracture (broken bone). LVN 1 stated the facility failed to provide Resident 1 with fall mat on both sides of the resident ' s bed. During a follow up interview on 11/14/2024 at 11:15 a.m. and a concurrent record review of nurse station 1 ' s Huddle Report, dated 10/2024 and 11/2024, reviewed with LVN 1, the Huddle Report indicated there were multiple days with Resident 1 not identified as high risk for falls. LVN 1 stated huddles were conducted at the start of every shift and the huddle report was completed. LVN 1 stated inconsistent information in the huddle book had the potential to cause confusion that may lead to an accident such as resident falls. During an interview on 11/14/2024 at 12:14 p.m., with the Director of Nursing (DON), the DON stated a huddle was a process to better communicate between the facility staff. The DON stated a huddle report should be done every shift. The DON stated the incomplete huddle reports meant the huddle was not done or the report was taken out for facility staff meeting purposes and was not returned in the huddle report binder. The DON stated Resident 1 had a risk for falls. The DON stated Resident 1 ' s fall mats should be on both sides of the resident ' s bed. The DON stated Resident 1 had the potential to fall and sustain an injury. The DON stated the facility failed to provide a fall mat on both sides of Resident 1 ' s bed for safety. During a review of the facility ' s policy and procedure (PnP) titled, Managing Falls and Fall Risk, last reviewed on 1/2024, the PnP indicated based on previous evaluation and current data, the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The PnP indicated if underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.